

Infection Control Program – Adult Care Center of the Northern Shenandoah Valley, Inc.

Manager: Marilyn Hamilton, RN, BSN

Regulation 22 VAC 40-61-280

Policy and Procedure for evidence- based infection control

The Staff receive two hours annual training specifically in infection control. (regulation 22VAC 40-61-140)

Supply list necessary to support quality control program.

Report of Outbreaks: See page 1, infection control manual for contact information.

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*Reviewed for content by Robert Dillingham, MD (Infection Control Committee, Winchester Medical Center)

Infection Control (IC) Checklist

Elements to be assessed	Yes	No	Notes
The facility has specified a person (e.g., staff, consultant) who is responsible for coordinating the IC program.	✓		
The facility has a process for reviewing infection surveillance data and infection prevention activities.	✓		
Written infection control policies and procedures are available and based on evidence-based guidelines.	✓		
Written infection control policies and procedures are reviewed at least annually or according to state or federal requirements, and updated if appropriate	✓		
The facility has a written plan for emergency preparedness (e.g., pandemic influenza or natural disaster).	✓		
The facility educates personnel on prompt reporting of signs/symptoms of a potentially transmissible illness to a supervisor.	✓		
Tuberculosis (TB) screening is required annually of all staff and volunteers.	✓		
The facility offers Hepatitis B vaccination to all personnel who may be exposed to blood or body fluids as part of their job duties.	✓		
The facility offers all personnel influenza vaccination annually.		✓	Center pays for those w/ no insurance.
The facility has an exposure control plan which addresses potential hazards posed by specific services provided by the facility (e.g., blood-borne pathogens). <i>Note: A model template, which includes a guide for creating an exposure control plan that meets the requirements of the OSHA Bloodborne Pathogens Standard is available at: https://www.osha.gov/Publications/OSHA3186.pdf</i>	✓		

<p>All personnel receive training and competency validation on managing a blood-borne pathogen exposure at the time of employment.</p> <p><i>Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an individual's duties.</i></p>	✓		
<p>The facility currently has a written policy for to assess risk for TB on admission.</p>	✓		
<p>The facility documents participant immunization status for pneumococcal vaccination at time of admission.</p>	✓		
<p>The facility has written intake procedures to identify potentially infectious persons at the time of admission.</p> <p><i>Examples: Documenting recent antibiotic use, and history of infections or colonization with C. difficile or antibiotic-resistant organisms</i></p>	✓		
<p>The facility has system for notification of infection prevention coordinator when antibiotic-resistant organisms or <i>C. difficile</i> are reported by clinical laboratory.</p>		✓	n/a
<p>The facility has a written surveillance plan outlining the activities for monitoring/tracking infections occurring in participants of the facility.</p>	✓		
<p>The facility has system to follow-up on clinical information, (e.g., laboratory, procedure results and diagnoses), when residents are transferred to acute care hospitals for management of suspected infections, including sepsis.</p> <p><i>Note: Receiving discharge records at the time of re-admission is not sufficient to answer "yes"</i></p>		✓	n/a

The facility has a written plan for outbreak response which includes a definition, procedures for surveillance and containment, and a list of syndromes or pathogens for which monitoring is performed.	✓		
The facility has a current list of diseases reportable to public health authorities.	✓		
The facility can provide point(s) of contact at the local or state health department for assistance with outbreak response.	✓		
Hand hygiene policies follow Department of Social Services licensing requirements.	✓		
All personnel receive training and competency validation on HH at the time of employment.	✓		
All personnel received training and competency validation on HH within the past 12 months.	✓		
Supplies necessary for adherence to HH (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible	✓		
The facility has a policy on Standard Precautions which includes selection and use of PPE (e.g., indications, donning/doffing procedures).	✓		
The facility has a policy on Transmission-based Precautions that includes the clinical conditions for which specific PPE should be used (e.g., <i>C. difficile</i> , Influenza).	✓		
Appropriate personnel receive job-specific training and competency validation on proper use of PPE at the time of employment.	✓		
Appropriate personnel received job-specific training and competency validation on proper use of PPE within the past 12 months.	✓		
Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible	✓		

All personnel receive education on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens	✓		
The facility has a policy on injection safety which includes protocols for performing finger sticks and point of care testing (e.g., assisted blood glucose monitoring, or AMBG).	✓		
Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures at time of employment.	✓		
Personnel who perform point of care testing (e.g., AMBG) receive training and competency validation on injection safety procedures within the past 12 months.	✓		
The facility has policies and procedures to track personnel access to controlled substances to prevent narcotics theft/drug diversion.	✓		Reg require that meds be locked up, so staff need access to med box. Strict pill counting/checking in place
The facility has written cleaning/disinfection policies.	✓		
The facility has written cleaning/disinfection policies which include cleaning and disinfection of high-touch surfaces in common areas.	✓		
The facility cleaning/disinfection policies include handling of equipment shared among residents (e.g., blood pressure cuffs, rehab therapy equipment, etc.).	✓		
Appropriate personnel receive job-specific training and competency validation on cleaning and disinfection procedures at the time of employment.	✓		
Appropriate personnel received job-specific training and competency validation on cleaning and disinfection procedures within the past 12 months.	✓		
The facility provides feedback to personnel regarding the quality of cleaning and disinfection procedures.	✓		we correct each other prn

Supplies necessary for appropriate cleaning and disinfection procedures (e.g., EPA-registered, including products labeled as effective against <i>C. difficile</i> and Norovirus) are available.	✓		
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Based on CDC checklist for LTC (9/2016).

Checklist completed 6/9/20, Mary Hamby, RN

**Exposure Control Plan
To Minimize Occupational exposure to Bloodborne Pathogens¹**

POLICY

The Adult Care Center of the Northern Shenandoah Valley, Inc. is committed to providing a safe and healthful work environment for our entire staff. In pursuit of this goal, the following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with Occupational Health and Safety Administration (OSHA) standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens".

PROGRAM ADMINISTRATION

The Executive Director and the Staff Registered Nurse (RN) are responsible for implementation of the ECP. The Executive Director, and/or the Staff RN will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures.

Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply the procedures and work practices outlined in the ECP.

The Executive Director and the Staff RN will provide and maintain all necessary personal protective equipment (PPE), engineering controls, labels, and red bags as required by the standard. The Executive Director and/or the Staff RN will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.

The Executive Director and the Staff RN will be responsible for ensuring that all medical actions required by the standard are performed and that appropriate employee health and OSHA records are maintained.

The Executive Director and the Staff RN will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives.

EMPLOYEE EXPOSURE DETERMINATION

The following is a list of all job classifications at the Center in which all employees have occupational exposure:

Anyone trained to perform first aid
Anyone trained to toilet participants

METHODS OF IMPLEMENTATION AND CONTROL

Universal Precautions

All employees will utilize universal precautions.

Exposure Control Plan

Employees covered by the bloodborne pathogens standard receive an explanation of this ECP during their initial training session, and it will be reviewed annually. All employees can review this plan at any time during the work shifts by contacting the Executive Director or the Staff RN. If requested, we will provide an employee with a copy of the ECP free of charge and within 15 days of the request.

The Executive Director and the Staff RN are responsible for reviewing and updating the ECP annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

Engineering Controls and Work Practices

Engineering controls and work practice controls will be used to prevent or minimize exposure to bloodborne pathogens. The specific engineering controls and work practice controls used are listed below:

- Insulin needles are kept locked up with insulin, sharps are disposed into sharps disposal containers.
- Sharps disposal containers are inspected or replaced by the Staff RN whenever necessary to prevent overfilling.

This facility identifies the need for changes in engineering controls and work practices through:

- Review of OSHA standards, CDC standards, staff input
- We evaluate new procedures and products by licensing regulations and evidence-based literature.
- Both front-line workers and management officials are involved in the process by exchange of information

The Executive Director and Staff RN are responsible for ensuring that these recommendations are implemented.

Laundry

Laundry soiled with blood will be bagged and discarded in the trash. Other laundry need not be professionally laundered. Bedding used by a participant need not be changed daily, but will be laundered before use by another participant.

Labels

Not applicable.

HEPATITIS B VACCINATION

The Staff RN will provide training to employees on hepatitis B vaccinations, addressing safety, benefits, efficacy, methods of administration, and availability.

The hepatitis B vaccination series is available to those at risk of coming into contact with bloodborne pathogens after initial training and within 10 days of assignment of duties. The Center will pay the co-pay of staff with health insurance. The Center will pay via the sliding scale at the health department for staff with no health insurance. Vaccination is encouraged unless: documentation exists that the employee has previously received the series, antibody testing reveals that the employee is immune, or medical evaluation shows that the vaccination is contraindicated.

If an employee declines the vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date at no cost. Documentation of refusal of the vaccine is kept in the employee's file.

POST-EXPOSURE AND FOLLOW-UP

Should an exposure incident occur, notify the Executive Director or Staff RN. Following initial first aid (clean the wound, flush eyes or other mucous membranes, etc.), the employee will be sent to Urgent Care for evaluation and testing for HBV and HIV serological status (with the employee's consent).

The following activities will then be performed:

- Document the routes of exposure and how the exposure occurred.
- Identify and document the source individual (unless the employer can establish that identification is infeasible or prohibited by state or local law).
- Obtain consent and make arrangements to have the source individual tested as soon as possible to determine HIV, HCV, and/or HBV infectivity. Document that the source individual's test results were conveyed to the employee's health care provider.

- If the source individual is already known to HIV, HCV and/or HBV positive, new testing need not be performed.
- Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).

ADMINISTRATION OF POST-EXPOSURE EVALUATION AND FOLLOW-UP

The Executive Director or Staff RN will ensure that the employee receives a copy of OSHA's bloodborne pathogens standard.

The Executive Director or Staff RN will ensure that the employee's health care provider receives the following:

- A description of the employee's job duties relevant to the exposure incident.
- Route(s) of exposure
- Circumstances of exposure
- Relevant employee medical records, including vaccination status

PRODEDURES FOR EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

The Executive Director or Staff RN will review the circumstances of all exposure incidents to determine:

- Engineering controls in use at the time
- Work practices followed
- A description of the device being used (including type and brand)
- Protective equipment or clothing that was used at the time of the exposure incident (gloves, eye shields, etc.)
- Procedure being performed when the incident occurred
- Employee's training

The Executive Director or Staff RN will record all percutaneous injuries from contaminated sharps in a Sharps Injury Log.

If revisions to this ECP are necessary, the Executive Director, Assistant Director, or Staff RN will ensure that appropriate changes are made. Changes may include an evaluation of safer devices, adding employees to the exposure determination list, etc.

- Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).

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EMPLOYEE TRAINING

All employees who have occupational exposure to bloodborne pathogens receive initial and annual training conducted by the Executive Director or Staff RN.

All employees who have occupational exposure to bloodborne pathogens receive training on the epidemiology, symptoms, and transmission of bloodborne pathogen diseases. In addition, the training program covers, at minimum, the following elements:

- A copy and explanation of the OSHA bloodborne pathogen standard
- An explanation of our ECP and how to obtain a copy
- An explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident
- An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
- An explanation of the basis for PPE selection
- Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and the vaccine will be offered free of charge
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
- An explanation of the procedure to follow if an exposure incident occurs including the method of reporting the incident and the medical follow-up that will be made available
- Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident
- an opportunity for interactive questions and answers with the person conducting the training session

Training materials for this facility are available in a notebook located in the nurse's office.

RECORDKEEPING

Training Records

Training records are completed for each employee upon completion of training. These records are kept for at least three years in the employee's files.

The training records include:

- The dates of training sessions
- The contents or a summary of the training sessions
- The names and qualifications of persons conducting the training
- The names and job titles of all persons attending the training sessions

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to the Executive Director, Assistant Director, or Staff RN.

Medical Records

Any medical records will be kept in the employee file.

OSHA Recordkeeping

An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904):

1904.1(a)(1)

If your company (The Adult Care Center) had ten (10) or fewer employees at all times during the last calendar year, you do not need to keep OSHA injury and illness records unless OSHA or the BLS informs you in writing that you must keep records under § 1904.41 or § 1904.42. However, as required by § 1904.39, all employers covered by the OSH Act must report to OSHA any workplace incident that results in a fatality or the hospitalization of three or more employees.

This determination and the recording activities are done by the Executive Director, Assistant Director, or Staff RN.

Sharps Injury Log

In addition to the 1904 Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in a Sharps Injury Log. All incidences must include at least:

- date of the injury
- type and brand of the device involved (such as syringe, suture needle)
- work area where the incident occurred
- explanation of how the incident occurred.

This log is reviewed as part of the annual program evaluation and maintained for at least five years following the end of the calendar year covered. If a copy is requested by anyone, it must have any personal identifiers removed from the report.

¹OSHA model template: <https://osha.gov/Publications/osha3186.pdf>

Signature: James Braukrecht Date: 6-11-2020

HEPATITIS B VACCINE DECLINATION (MANDATORY)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee signature: Jane Brauknecht . Date: 6-11-2020

**Training Information About Hepatitis B Vaccination, to Include:
Safety, Benefits, Efficacy, Method of Administration, and Availability
(per OSHA)¹**

Safety: The Hepatitis B vaccine is very safe. Some people report having very mild side effects, such as a sore arm from the shot or a fever. On extremely rare occasions, people may experience severe anaphylactic allergic reactions. The vaccine is not recommended for anyone who is allergic to yeast or any other component of the vaccine. The Centers for Disease Control (CDC) and the Federal Drug Administration (FDA) continually monitor the safety of vaccines after they are approved. The vaccine contains no live virus, and is safe to administer during pregnancy or lactation.

Benefits and Efficacy: The most common vaccine is given in a series of three vaccinations; initial, one month later, and six months later than the second dose. A new formulation, Heplisav-B, is approved for two doses one month apart. After three doses, 80-100% of healthy adults develop adequate antibody response. No additional boosters are needed. There is an age-specific decline in immunogenicity. After age 40 years, approximately 90% of recipients respond to three doses, and by 60 years only 75% develop protective antibody titers.

Method of Administration: intramuscular injection.

Availability: The vaccine is readily available at local Urgent Care centers, local health departments and physicians' offices.

¹CDC.gov

Understanding Infection Transmission ¹

How Infections Spread

Bacteria and viruses are found in air, soil, water, and in and on our bodies. Some are helpful, others are harmful. Many bacteria/viruses live in and on our bodies without causing harm and some even help us to stay healthy. Only a small portion of bacteria/viruses are known to cause infection.

How Infections Occur

An infection occurs when bacteria/viruses enter the body, increase in number, and cause a reaction of the body.

Three things are necessary for an infection to occur:

- **Source:** Places where infectious agents live (i.e., sinks, surfaces, human skin)
- **Susceptible Person:** Someone who could be sickened by the bacteria/virus
- **Transmission:** The way bacteria/viruses are moved to the susceptible person

A source is an infectious agent and refers to a virus, bacteria, or other microbe. Sources include people, wet/damp surfaces, indwelling medical devices, dust and decaying debris.

A susceptible person is someone who is not vaccinated or otherwise immune, or a person with a weakened immune system. For an infection to occur, the bacteria/virus must enter a susceptible person's body and invade tissues, multiply, and cause a reaction. Patients who have underlying medical conditions such as diabetes, cancer, and organ transplantation are at increased risk for infection due to reduced immune system function. Certain medications such as antibiotics, steroids, and some cancer treatments also reduce the immune response. Catheters and surgery

increase the risk of infection by allowing bacteria/viruses to gain entry into the body.

Transmission refers to the way the source is moved to the susceptible person. The source of infection depends on people and the environment. There are four general ways that infectious sources are transferred: through contact (i.e., touching), sprays and splashes, inhalation, and sharps injuries.

Contact transmission moves the infective agent by touch. For example, if your hands become contaminated and you touch a susceptible person without performing proper hand hygiene, the susceptible person may become ill.

Sprays and splashes can occur when an infected person coughs or sneezes, creating droplets which carry the infectious agent short distances. Body fluids may also transmit bacteria/viruses.

Airborne transmission occurs when the infectious agent is aerosolized into tiny particles that can survive on air currents over distance to reach a susceptible person.

Injuries from a contaminated sharp object can transmit blood-borne pathogens.

In addition, disease transmission may also involve vectors such as ticks or mosquitoes.

Consequently, breaking transmission is key to reducing transmission of infections.

How to Break Transmission

Universal Precautions.

Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens.

Universal precautions are intended to prevent parenteral (outside the gastrointestinal tract), mucous membrane, and nonintact skin exposures of health-care workers to bloodborne

pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood.

Body fluids to which Universal Precautions apply.

Universal precautions apply to blood and to other body fluids containing visible blood.

Occupational transmission of HIV and HBV to health-care workers by blood is documented. Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the occupational setting. Infection control efforts for HIV, HBV, and other bloodborne pathogens must focus on preventing exposures to blood as well as on delivery of HBV immunization.

Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV and HBV, they have not been implicated in occupational transmission from patient to health-care worker.

Universal precautions also apply to tissues and to the following fluids: Cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk of transmission of HIV and HBV from these fluids is unknown.

Body fluids to which Universal Precautions do not apply.

Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood.

Avoiding contact

Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices. Take care when handling sharp instruments after procedures, when cleaning used instruments, and when disposing of used needles. Do not recap used needles by hand, and do not

remove used needles from disposable syringes by hand. Do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades, and other sharp items in puncture-resistant containers for disposal. Locate the puncture-resistant containers as close to the use area as is practical.

Use protective barriers to prevent exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. The type of protective barrier(s) should be appropriate for the procedure being performed and the type of exposure anticipated (i.e., gloves, eye-protection if necessary).

Immediately and thoroughly wash hands and other skin surfaces that are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply.

Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions *except* sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include hand hygiene, use of gloves, gown, mask, eye protection or face shield (depending on the anticipated exposure) and safe injection practices.

Consequently, we will perform hand hygiene and wear disposable gloves while handling food, providing perineal care, after use the toilet, performing finger stick for blood glucose, providing wound care/ contact with broken skin, and injecting insulin. There are disposable masks and gowns available if needed.

Staff will follow the policy for respiratory hygiene and cough etiquette.

Contact precautions

In the event of a suspected norovirus or *Clostridium difficile* infection, the procedures include detailed instructions to isolate the participant and decontaminate affected areas. In the event of a suspected shingles infection, the policy includes detailed instructions on wrapping exposed open blisters.

Droplet precautions

In the event of a suspected influenza or pertussis infection, the procedures include detailed instructions to isolate the participant and decontaminate affected areas. COVID-19 is believed to be transmitted by droplet, and those procedures are addressed in COVID-19 Policies and Procedures.

Airborne Precautions

In the event of a suspected measles, chickenpox or tuberculosis infection, the procedures include detailed instructions to isolate the participant and decontaminate affected areas.

Approved: Jane Baucke. Date: 6-11-2020

¹CDC: <https://www.cdc.gov/infection-control/index.html> (multiple tabs)

Policy for Reporting Outbreaks

The Virginia Department of Health (VDH) requires suspected or confirmed cases of the following diseases be reported immediately:

Disease caused by an agent that may have been used as a weapon
Outbreaks¹, all (including but not limited to foodborne, healthcare-associated, occupational, toxic
substance-related, waterborne, and any other outbreak)
Unusual occurrence of disease of public health concern

Nursing staff or a director must inform the Winchester-Frederick County Health Department at 722-3470.

Source: VDH Virginia Reportable Disease List, November 2018

¹An outbreak is defined by VDH as “ the occurrence of more cases of disease than expected. There is no strict definition of an outbreak or specific number of cases that need to occur to be considered an outbreak. If an outbreak is suspected, it should be reported.” Source: Outbreak Reporting Requirements for Facilities and Programs, September 2018.

Signature: Jane Brauknecht . Date: 10-11-2020

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WINCHESTER-FREDERICK COUNTY HEALTH DEPARTMENT

Frederick Winchester Medical Health Dept
10 Baker St · (540) 722-3470
Closes 4:30PM

Frederick Winchester Environmental Health

107 N Kent St # 201 · (540) 722-3480
Closes 4:30PM

Meredith Davis, MPH, District Epidemiologist with the Virginia Department of Health,

CDC (Center for Disease Control)

www.cdc.gov
800-232-4636

Use the online form or call 800-232-4636 (800-CDC-INFO) Monday-Friday, from 8:00 am ET to 8:00 pm ET. This is an integrated CDC hotline service. Callers to this number are given several options.

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Policy for Reviewing Infection Surveillance Data and Infection Prevention Activities

Each quarter the Staff Registered Nurse or a director will review the list (List of Infectious Diseases Diagnosed Among Participants) of infectious diseases diagnosed. Any suspected trends will be reported to the Winchester-Frederick County health department at 722-3470.

When any illness appears to be increasing in frequency, staff will decontaminate surfaces at the direction of nursing staff or director. This decontamination will be documented in the List of Infectious Diseases Diagnosed Among Participants.

Approved: *Jane Baucke* Date: *6-11-2020*

Per Infection Control Checklist



Policy for Use of Disposable Gloves¹

Gloves shall be worn to perform the following tasks:

1. Serving food or beverages
2. Feeding assistance
3. Providing perineal care
4. Touching broken skin
5. Wound care
6. Fingerstick
7. Insulin administration
8. Touching surfaces which may be contaminated
9. Handling clothing soiled with urine, feces, or other body fluids
10. Cleansing urine, feces or other body fluids from surfaces

Gloves do not replace hand hygiene. Any task that requires gloving should be preceded by hand hygiene. Perform hand hygiene after removal of gloves. Change gloves between providing care to different participants.

Remove gloves in such a way as to avoid contaminating the hands:

1. Grasp the outside of one glove at the wrist. Do not touch your bare skin.
2. Peel the glove away from your body, pulling it inside out.
3. Hold the glove you just removed in your gloved hand.
4. Peel off the second glove by putting your fingers inside the glove at the top of your wrist.
5. Turn the second glove inside out while pulling it away from your body, leaving the first glove inside the second.
6. Dispose of the gloves in the trash. Do not reuse the gloves.

Signature: Jane Blauknecht Date: 6-11-2020

¹CDC: <https://www.cdc.gov/vhf/ebola/pdf/poster-how-to-remove-gloves.pdf>

Procedure for Disinfecting/Sanitizing Surfaces

I Purpose and background information

A 10% Clorox solution will disinfect hard surfaces, killing all bacteria, viruses (including norovirus) and *Clostridium difficile* spores. The solution must be prepared daily, and a generic brand not substituted unless Clorox is not available. The solution must be rinsed off the surface. Upholstered furniture must be professionally steam-cleaned.

A 200 parts per million (ppm) Clorox bleach solution prepared with room temperature water is used to sanitize tabletops, and must be prepared daily. A generic brand cannot be substituted unless Clorox is not available. Disinfecting during the community-spread of COVID-19 is addressed in COVID-19 Policies and Procedures.

II Definitions

All terms are defined in the procedure.

III References

CDC: <https://www.cdc.gov/norovirus/about/prevention.html>

CDC: <https://www.cdc.gov/cdiff/prevention.html>

Clorox: <https://www.clorox.com/how-to/disinfecting-sanitizing/disinfecting-with-bleach/sanitizing-food-contact-surfaces-and-equipment>

IV Procedure

A. To prepare a 10% Clorox solution:

1. Add 2 cups cold tap water to the container. Add ¼ cup of Clorox bleach to the water, and stir gently to thoroughly mix. Do not splash onto skin or into eyes.
2. If solution splashes onto skin, rinse immediately with cold water.

3. If solution splashes into an eye, immediately flush with running cold water, and ask a staff member to call 911.
4. Apply gloves, squeeze out excess, solution and wipe all hard surfaces. Start with the 'cleanest' surfaces (i.e., tables, chairs, doorknobs, door code entry, etc.) and proceed to the 'dirtiest' surfaces (i.e., toilets, flushing handles, stall door handles, sink, faucets, soap dispensers, etc.). Repeat the soaking/squeezing sequence every two minutes.
5. Allow the disinfecting solution to sit on surfaces for 10 minutes. Do not allow staff or participants to touch the wet surfaces. Wipe dry.
6. Change gloves and collect at least 2 cups of fresh tap water in a suitable basin. Soak a clean paper towel or clean gauze in the water, squeeze almost dry, and rinse disinfected surfaces, rinsing towel/gauze often in the rinse water. Change the rinse water and towel when half-way through the procedure. Allow surfaces to dry before use.

B. To prepare a 200 ppm Clorox solution:

1. Add ½ teaspoon of Clorox bleach to two cups of room temperature water. Mix well.
2. Spray table surface with the mixture until the surface glistens, and let sit for two minutes.
3. Wipe dry with a clean cloth/paper towel.

V Document Control

The procedure may be approved by the Director or the Staff Registered Nurse (RN).

Revisions may be made by the Director, the RN, or a designee selected by the Director or Staff RN. Notes may be made on the procedure, but must be dated and initialed.

Approved: Jane Baucknecht Date: 6-11-2020

Policy for Respiratory Hygiene and Cough Etiquette¹

All staff will cover the mouth and nose with a tissue when coughing or sneezing. If a tissue is not available, sneeze/cough into the crook of the arm. Use the nearest waste receptacle to dispose of the tissue after use. Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials.

Signature: Jan Hauknecht . Date: 6-11-2020

¹<https://www.cdc.gov/oralhealth/infectioncontrol/faqs/respiratory-hygiene.html>

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Shingles Policy¹

Shingles is a viral infection that causes a painful rash. Although shingles can occur anywhere on the body, it most often appears as a single stripe of blisters that wraps around either the left or the right side of the torso. Shingles is caused by the varicella-zoster virus (the same virus that causes chickenpox). After recovery from chickenpox, the virus lies inactive in nerve tissue near the spinal cord and brain. Years later, the virus may reactivate as shingles. Symptoms include: Pain, burning, numbness or tingling; sensitivity to touch; a red rash that begins a few days after onset of pain; fluid-filled blisters that break open and crust over; and itching. Some also experience fever, headache, sensitivity to light, and fatigue. Pain is usually the first symptom, and some experience shingles pain without developing the rash.¹

Shingles cannot be transmitted from one person to another. However, while the blisters are present and opening, the person may transmit chicken pox to someone who has never had the disease or been vaccinated against it. A vaccine, Shingrix, is effective to prevent shingles for at least four years.¹

If shingles is suspected while a participant is present, apply gloves and cover any visible open blisters with sterile gauze. The participant should be isolated from others and sent home immediately.

If a participant is diagnosed with shingles, he/she should remain at home for 24 hours after diagnosis before attending the Center. The participant may then return, but the blisters must be covered with sterile gauze until scabbing is complete.

¹Mayoclinic.org

Signature: *Jane Brunkert* Date: 6-11-2020

Procedure for Performing Hand Hygiene

I Purpose and Background Information

Practicing correct hand hygiene reduces transmission of infective organisms. Standards and Regulations for Licensed Adult Day Care Centers dictate the method of hand hygiene.

Hands must be washed:

1. Prior to preparing or serving food
2. Prior to administering medication
3. Prior to assisting a participant with meals/snacks/beverages
4. Upon leaving the bathroom
5. After using the toilet
6. Prior to perform wound care, finger sticks, or any contact with broken skin
7. After blowing your nose
8. At additional times, as dictated by the Executive Director or nurse

II Definitions

All terms are defined in the text.

III References

1. CDC: <https://www.cdc.gov/handhygiene/index.html>
2. Perry, A.G. and Potter, P. A. Clinical Nursing Skills and Techniques. Elsevier Mosby, St. Louis, MO. 6th edition. 2006, p. 192-196.

IV Procedure

A. Use soap and water:

1. Push sleeves and watch (if worn) above wrists. Turn on water, and regulate flow

of water so that the temperature is warm. Wet hands and wrists thoroughly under running water. Keep hands and forearms lower than elbows during washing.

Avoid touching the sink.

2. Apply a small amount of soap and rub hands together to produce plenty of lather.
3. Perform hand hygiene for at least 20 seconds, interlacing fingers and rubbing palms and back of hands with circular motion at least 5 times each. Keep fingertips down to facilitate removal of microorganisms.
4. Clean underneath fingernails with the fingernails of the other hand and additional soap, or gently cleanse with an orangewood stick.
5. Rinse hand and wrists thoroughly, keeping hands down and elbows up. If the hands touch the sink during hand hygiene, repeat the procedure.
6. Dry hands thoroughly with a clean paper towel, and discard towel.
7. Turn off the faucet with a clean paper towel.
8. Apply lotion to hands to minimize skin dryness.
9. Using alcohol-based hand sanitizer (ABHS) does not substitute for washing with soap and water at the Center.

B. Using ABHS to cleanse participants' hands prior to meals/snacks:

1. Dispense approximately ½ teaspoonful of ABHS onto the participant's hand, allowing the sanitizer to fall into the hand (avoiding contaminating the tip of the dispenser). Supervise to ensure that the sanitizer is not consumed/rubbed into the eye, etc.
2. Encourage the participant to rub the sanitizer over the hands until dry. Rub the sanitizer over the hands if the participant is unable to do so.

3. Note: This is not the full protocol recommended by the Centers for Disease Control for correct hand hygiene using ABHS, but an abbreviated version for participant use at the Center before meals.

C. Using ABHS to cleanse participant's hands after toileting when he/she is unable to stand at the sink:

1. Dispense approximate $\frac{1}{2}$ teaspoonful of ABHS onto participant's hand.
2. Rub the sanitizer over the hands, including under rings, if possible.
3. Rub until dry, approximately 20 seconds.

V. Document Control

The procedure may be approved by the Director or the Staff Registered Nurse (RN). Revisions may be made by the Director or the Staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Approved: Jane Bauckrecht Date: 6-11-2020

Procedure to Follow in the Event of a Suspected Case of Measles, Chickenpox or Tuberculosis

I Purpose and Background Information

Measles is an acute viral respiratory illness. Although the risk to the participant population should be small, the United States has had an increased rate of measles in 2019. The disease begins with high fever, cough, reddened eyes, and the appearance of Koplik spots (cluster of white spots inside the mouth). Three to five days later, a rash appears. The rash starts as small red flat spots at the hairline, and spreads downward. Small raised red bumps may appear on top of the flat red spots. Measles is extremely contagious, and prompt action would be imperative.

Airborne precautions should be implemented. The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes. The measles virus can remain infectious in the air for up to two hours after an infected person leaves an area. Infected persons are considered to be contagious from four days before until four days after the rash appears. Sometimes immunocompromised patients do not develop the rash.

Chickenpox is a highly contagious disease caused by the varicella-zoster virus (VZV). It can cause an itchy, blister-like rash. The rash first appears on the chest, back, and face, and then spreads over the entire body. The classic symptom of chickenpox is a rash that turns into itchy, fluid-filled blisters that eventually turn into scabs. The rash may first

show up on the chest, back, and face, and then spread over the entire body, including inside the mouth, eyelids, or genital area. It usually takes about one week for all of the blisters to become scabs. Other typical symptoms that may begin to appear 1-2 days before rash include fever, tiredness, loss of appetite, and headache. Some people who have been vaccinated against chickenpox can still get the disease. However, the symptoms are usually milder, with fewer or no blisters (or just red spots), mild or no fever, and shorter duration of illness. Some vaccinated people who get chickenpox may have disease similar to unvaccinated people. The varicella-zoster virus also causes shingles. Chickenpox can be spread from people with shingles to others who have never had chickenpox or received the chickenpox vaccine through exposure to blister contents.

Tuberculosis (TB) is generally a respiratory infection, caused by *Mycobacterium tuberculosis*. The bacteria usually affect the lungs (pulmonary TB), but TB bacteria can grow in any part of the body such as the kidney, spine, and brain. It is an airborne disease spread through coughing, speaking, and singing.

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB disease in the lungs may cause symptoms such as a bad cough that lasts 3 weeks or longer, pain in the chest, or coughing up blood. Other symptoms include weakness or fatigue, weight loss, lack of appetite, chills, fever, and sweating at night. Symptoms of TB disease in other parts of the body depend on the area affected.

II Definitions

All terms are defined in the text.

III References

CDC: <https://www.cdc.gov/measeles/index.html>

CDC: <https://www.cdc.gov/chickenpox/index.html>

CDC <https://www.cdc.gov/TB/index.html>

IV Procedure

- A. If symptoms of measles, chickenpox, or TB are noted, immediately remove the participant and one staff member to the nearest unused room and close the door. The attending staff member should wash her/his hands before entering the room. Notify family and ask them to pick up their loved one immediately.
- B. Staff will pass N-95 respirator masks to the confined staff member and the participant. Refer to Procedure for Fitting a N-95 Respiratory Mask for fitting and disposal instructions. N-95 respirator masks are located in the second men's bathroom. Contact isolation masks are not a substitute for N-95 respirator masks.
- C. No one except emergency personnel should enter the room. When the family arrives, the participant should be transported quickly through the building by wheelchair, to minimize exposure to others.
- D. Request that the family inform the Center of any diagnosis made.
- E. The occupied room will remain closed until the next business morning. Post a notice on the door instructing the cleaning crew to leave the door closed, and seal with yellow CAUTION tape. CAUTION tape is located in the second men's

bathroom. No disinfecting protocol is necessary.

V Document Control

The procedure may be approved by the Director or the Staff Registered Nurse (RN).

Revisions may be made by the Executive Director or staff RN. Notes may be made on the procedure by the Executive Director or staff RN, but must be dated and initialed.

Signature: Jane Bauknecht Date: 6-11-2020

Procedure for Fitting a N-95 Respirator Mask

I Purpose and background information

A N-95 respirator mask is required for airborne isolation. In the unlikely event that a participant shows symptoms of measles or chicken pox, a N-95 respirator mask must be worn by attendant staff and the participant (if possible). The mask must be correctly fitted to work properly.

II Definitions

All terms are defined in the text.

III References

1. OSHA respiratory protection standard 29 CFR 1910.134
2. CDC: <https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf>

IV Procedure

- A. Wash hands.
- B. Position the mask in your hand, with the nose piece near the tips of your fingers, allowing the elastic bands to fall below the mask.
- C. Hold respirator up to your chin, with nosepiece up. Do not allow any facial hair or jewelry to interfere with contact between skin and mask.
- D. The top strap goes over and rests at the top back of the head. The bottom strap is positioned around the neck and below the ears. The two straps should not cross.
- E. Place your fingertips from both hands at the top of the metal nose clip. Slide fingertips down both sides of the metal strip to mold the nose area to the shape of your nose.
- F. Place both hands over the respirator and take a quick breath in to check whether the

respirator seals tightly to the face.

- G. Place both hands completely over the respirator and exhale. If you feel leakage, there is not a proper seal.
- H. If air leaks around the nose, readjust the nosepiece as described. If air leaks at the mask edges, re-adjust the straps along the sides of your head until a proper seal is achieved.
- I. If you cannot achieve a proper seal due to air leakage, ask for help.
- J. To remove the respirator, pull the bottom strap over the back of your head, followed by the top strap, **without touching the respirator**. The exterior of the respirator is assumed to be contaminated.
- K. Discard respirator into the trash and wash your hands.

V Appendix

Appendix A follows this procedure, and illustrates the procedure..

VI Document Control

The procedure may be approved by the Executive Director or Staff Registered Nurse (RN). Revisions may be made by the Executive Director or Staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

How to Properly Put on and Take off a Disposable Respirator

WASH YOUR HANDS THOROUGHLY BEFORE PUTTING ON AND TAKING OFF THE RESPIRATOR.

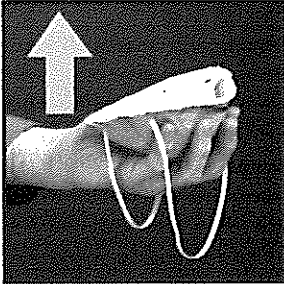
If you have used a respirator before that fit you, use the same make, model and size.

Inspect the respirator for damage. If your respirator appears damaged, **DO NOT USE IT**. Replace it with a new one.

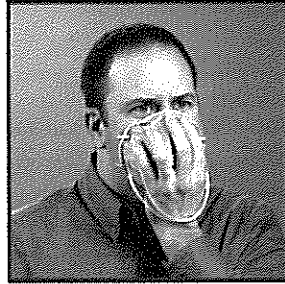
Do not allow facial hair, hair, jewelry, glasses, clothing, or anything else to prevent proper placement or come between your face and the respirator.

Follow the instructions that come with your respirator.¹

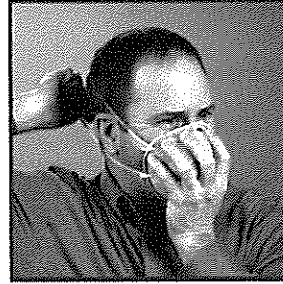
Putting On The Respirator



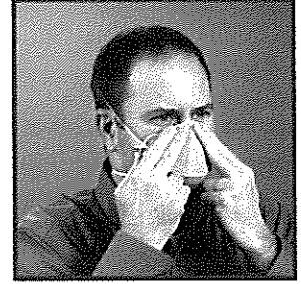
Position the respirator in your hands with the nose piece at your fingertips.



Cup the respirator in your hand allowing the headbands to hang below your hand. Hold the respirator under your chin with the nosepiece up.



The top strap (on single or double strap respirators) goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears. Do not crisscross straps.



Place your fingertips from both hands at the top of the metal nose clip (if present). Slide fingertips down both sides of the metal strip to mold the nose area to the shape of your nose.

Checking Your Seal²



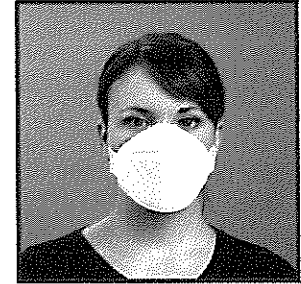
Place both hands over the respirator, take a quick breath in to check whether the respirator seals tightly to the face.



Place both hands completely over the respirator and exhale. If you feel leakage, there is not a proper seal.



If air leaks around the nose, readjust the nosepiece as described. If air leaks at the mask edges, re-adjust the straps along the sides of your head until a proper seal is achieved.

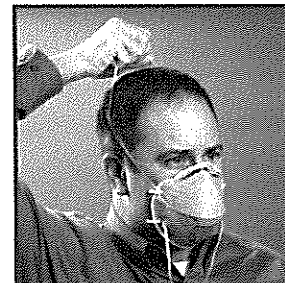


If you cannot achieve a proper seal due to air leakage, ask for help or try a different size or model.

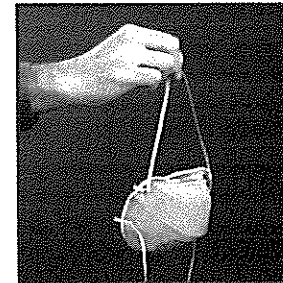
Removing Your Respirator



DO NOT TOUCH the front of the respirator! It may be contaminated!



Remove by pulling the bottom strap over back of head, followed by the top strap, without touching the respirator.



Discard in waste container.
WASH YOUR HANDS!

Employers must comply with the OSHA Respiratory Protection Standard, 29 CFR 1910.134 if respirators are used by employees performing work-related duties.

¹ Manufacturer instructions for many NIOSH approved disposable respirators can be found at www.cdc.gov/niosh/npptl/topics/respirators/disp_part/

² According to the manufacturer's recommendations

For more information call 1-800-CDC-INFO or go to <http://www.cdc.gov/niosh/npptl/topics/respirators/>





Procedure to Follow in the Event of a Suspected Case of Influenza or Pertussis (Whooping Cough)

I Purpose and Background Information

Influenza ('flu') symptoms usually appear very suddenly, often within 30 minutes.

Symptoms include fever (although not everyone will present with fever), cough, sore throat, runny nose, body aches, headache, tiredness. Other symptoms may include vomiting and diarrhea.

Pertussis (whooping cough) is a highly contagious respiratory disease. It is caused by the bacterium *Bordetella pertussis*. Symptoms include uncontrollable, violent coughing which often makes it hard to breathe. After coughing, the recovery deep breaths often produce a "whooping" sound.

Influenza and pertussis both require droplet isolation precautions, which include contact isolation masks.

II Definitions

All terms are defined in the procedure.

III References

1. CDC: <https://www.cdc.gov/flu/index/htm>
2. CDC: <https://www.cdc.gov/pertussis/index/htm>

IV Procedure

A. If symptoms of influenza or pertussis are suspected, immediately remove the

participant to the nearest unused room and close the door. One staff member will remain with the participant. Notify family, and ask them to pick up the participant immediately.

- B. Staff will pass contact isolation masks to the confined staff member and the participant. No one except emergency personnel should enter the room.
Masks are located in the men's second bathroom.
- C. When the caregiver arrives, the participant should be quickly escorted through the building by wheelchair to minimize exposure to others.
- D. Request that the family inform the Center of any diagnosis. The participant can return when the healthcare provider gives permission to do so.
- E. Decontaminate the room as described in the Procedure for Disinfecting Surfaces.

V Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director, or Staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Approved: Jane Baucknecht Date: 6-11-2020

Procedure to Break Transmission of Suspected Norovirus Infection

I. Purpose and Background Information

The purpose of this procedure is to establish a protocol for the containment of suspected norovirus. Based on information published by the Centers for Disease Control (CDC), noroviruses cause acute gastroenteritis in persons of all ages. The illness typically begins after an incubation period of 12-48 hours and is characterized by acute onset, non-bloody diarrhea, vomiting, nausea, and abdominal cramps. Some persons might experience only vomiting or diarrhea. Low-grade fever and body aches also might be associated with infection, and thus the term "stomach flu" often is used to describe the illness, although there is no biologic association with influenza.

Although symptoms might be severe, they typically resolve without treatment after 1-3 days in otherwise healthy persons. The time after illness at which an infected person is no longer contagious also is unknown. In addition, those with preexisting antibodies were not protected from infection unless repeated exposure to the same strain occurred within a short period. Because the virus can be transmitted by food, water, and contaminated environmental surfaces as well as directly from person to person, and because there is no long-lasting immunity to norovirus, outbreaks can occur in a variety of institutional settings (e.g., nursing homes, hospitals, and schools) and affect people of all ages.

Norovirus is extremely contagious, with an estimated infectious dose as low as 18 viral particles, suggesting that approximately 5 billion infectious doses might be contained in each gram of feces during peak shedding. Humans are the only known reservoir for human norovirus infections. Transmission occurs by three routes; person-to-person,

foodborne, and waterborne. Person-to-person transmission might occur directly through the fecal-oral route, by ingestion of aerosolized vomitus, or by indirect exposure via contaminated surfaces. Overall, studies suggest that proper hand washing with soap and running water for at least 20 seconds is the most effective way to reduce norovirus contamination on the hands. As an additional preventive strategy, no bare-hand contact with ready-to-eat foods (foods edible without washing, cooking, or additional preparation to achieve food safety) is recommended. Considering the highly infectious nature of norovirus, exclusion and isolation of infected persons are often the most practical means of interrupting transmission of virus and limiting contamination of the environment. Chlorine bleach solution (10% Clorox) should be applied to hard, nonporous, environmental surfaces at a concentration of approximately 5,000 ppm. Bleach solutions should be freshly prepared.

II. Definitions

All terms are defined in the text.

III. References

CDC: <https://www.cdc.gov/infectioncontrol/guidelines/norovirus/index.html>

IV. Procedure

In the event that a participant becomes ill with symptoms consistent with norovirus infection (i.e., repeated episodes of vomiting and/or diarrhea in a short amount of time):

- A. If possible, remove the participant to one of the private bathrooms, using a wheelchair if necessary. Only the attendant staff member should remain with the participant, and should then apply a disposable gown, mask, and gloves. When family/caretaker

arrives, the ill participant should be promptly transferred to the car via wheelchair by non-attendant staff. After the participant has left the building, the attendant staff will decontaminate the bathroom.

1. Non-attendant staff should prepare the bleach solution (i.e., add $\frac{1}{4}$ cup of Clorox to 2 cups water, mixing gently) and deliver it and a roll of paper towels to the attending staff without entering the room. Attendant staff should prop open the door for ventilation, apply clean gloves, soak towel with solution, squeeze dry, and wipe all surfaces liberally with the bleach solution (including doorknobs, toilet flusher, soap dispenser, spigots, etc.) and allow the solution to sit for 10 minutes.
 2. Rinse surfaces by dipping a clean paper towel into water, using fresh water half-way through the procedure. Lastly, mop the floor with the bleach solution, and allow it to dry.
 3. When decontamination is complete, attendant staff should remove gown, mask, and gloves. Bag all trash twice. The wheelchair and any other equipment which came into contact with the ill participant or attendant staff (including the bathroom of origin, if applicable) should be decontaminated as described above.
- B. If it is not possible to remove the participant to a private bathroom, use one stall and one sink, minimizing contamination of surfaces. No other participant should be allowed to use the designated stall and sink.
- C. A participant diagnosed with norovirus must remain at home until the health care provider has given permission for her/him to return.

V. Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director, or the Staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Signature: Jane Bauckrecht Date: 6-11-2020

Procedure to Follow in the Event of Suspected *Clostridium difficile* (*C. diff*)

I Purpose and Background Information

C.diff bacteria causes life-threatening diarrhea. It is usually a side-effect of taking antibiotics. These infections mostly occur in people 65 and older who take antibiotics and receive medical care, people staying in hospitals and nursing homes for a long period of time, and people with weakened immune systems or previous infection with *C. diff*. Symptoms might start within a few days or several weeks after administration of antibiotics. Symptoms include diarrhea, fever, stomach tenderness, loss of appetite, and nausea. The diarrhea has a distinctive, unpleasant, sweet smell.

The infection is very easily spread. The bacteria are readily killed, but reproduce by forming spores. These spores are very difficult to destroy, and can easily spread (i.e., soles of shoes, objects in a room, etc.). A 10% fresh Clorox bleach solution will kill *C.diff* spores (see Procedure for Disinfecting Surfaces)

C. diff is a major health threat. A 2015 CDC study found that it caused almost half a million infections among patients in the United States in a single year. An estimated 15,000 deaths are directly attributable to *C. diff* infections, making it a substantial cause of infectious disease death in the United States. The bacteria are found in normal soil, and most healthy adults on exposure would not contract the disease. However, an immunosuppressed person would more likely contract the disease from the same exposure.

Strict adherence to contact isolation is key to avoiding transmission. Careful hand-

washing with soap and water is also required.

II Definitions

Definitions are defined in the text.

III References

1. CDC: cdc.gov/hai/organisms/cdiff/cdiff_infect.html
2. CDC: cdc.gov/cdiff/index.html
3. CDC: cdc.gov/cdiff/clinician/index.html

IV Procedure

In the event that a participant is suspected to have a *C. diff* infection:

- A. If possible, remove the participant to one of the private bathrooms, using a wheelchair if necessary. Only the attendant staff member should remain with the participant, and should then apply a disposable gown, mask, and gloves. While providing care, hands must be thoroughly washed with soap and water before and after applying gloves. Alcohol-based hand sanitizer will not kill *C. diff* spores. If the participant must move in and out of the bathroom, choose a nearby room without other participants present. The room must be decontaminated as thoroughly as possible after the participant leaves.
- B. When family/caretaker arrives, the participant should be promptly transferred to the car via wheelchair by non-attendant staff. After the participant has left the building, the attendant staff should decontaminate the bathroom.
 1. Non-attendant staff should prepare the 10% bleach solution (i.e., add ¼ cup of Clorox to 2 cups cold water, mixing gently) and deliver it and a roll of paper towels to the attending staff without entering the room. Attendant staff should

prop open the door for ventilation and wipe all surfaces liberally with the bleach solution (including doorknobs, toilet flusher, soap dispenser, spigots, etc.) and allow the solution to sit for 10 minutes. After this time, wipe surfaces dry with a clean paper towel. Rinse the surfaces with a wet paper towel, then allow the surfaces dry. Lastly, mop the floor with the bleach solution, and allow it to dry. Any bathroom used by the participant must be decontaminated.

2. When decontamination is complete, attendant staff should remove gown, mask, and gloves. Soles of shoes should be cleaned with soap and water.

The wheelchair and any other equipment which came into contact with the participant or attendant staff (including the bathroom of origin, if applicable) should be decontaminated as described above.
- C. If it is not possible to remove the participant to a private bathroom, use one stall and one sink. Any other staff and participants present should wash their hands with soap and water for 20 seconds, dry, and use a clean towel to turn off the water and open/close the door. The bathroom should not be used again until it can be decontaminated as described above, using fewest possible staff.
- D. The participant must be seen by a health care provider before returning to the Center. If diagnosed with *C. diff*, the participant may not return until the health care provider gives permission.

V Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or the staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Signature: Jane Bauckrecht Date: 6-11-2020

Procedure to Follow in the Event of a Needlestick

I Purpose and Background

If you stick yourself with a needle or have a sharps injury or are exposed to the blood or other body fluid of a another during the course of your work you are at risk of bloodborne infections such as HIV/AIDS, hepatitis B and hepatitis C. Prompt action reduces the risk of infection. A health care provider will decide on the appropriate post-exposure preventative care.

II Definitions

All terms are defined in the text.

III References

<http://www.cdc.gov/niosh/topics/bbp>

IV Procedure

- A. Immediately wash the broken skin with soap and water.
- B. Contact your supervisor, will follow the Exposure Control Plan.
- C. Seek medical attention immediately.

V Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or the staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Signature: *Jane Baucke cat* Date: 6-11-2020

Procedure for Monitoring for and Reporting Evidence of Bed Bug Infestation

I Purpose

To provide policies and procedures for the identification and reporting of any evidence of the presence of bed bugs at the Center.

II Definitions

All definitions are provided in the text.

III References

Fairfax Health District Procedural Memorandum. (March 6th, 2014). *Bed Bugs and Adult Day Health Care*.

Centers for Disease Control. (January 10, 2013). *Bed Bug FAQs*.
<http://www.cdc.gov/parasites/bedbugs/faqs.html>

Miller, D.M. *How to Identify a Bed Bug Infestation*. (Date unknown). Virginia Department of Agriculture and Consumer Services. Located on March 29, 2014 at <http://www.vdacs.virginia.gov/pesticides/pdf/files/bb-identify1.pdf>

IV Associated Documents

Bed Bug Inspection Log

V Procedure

A. Background information

The bed bug is a parasitic reddish-brown, oval flattened insect about one quarter inch long. Bed bugs feed on the blood of warm-blooded hosts. They occur world wide, without regard to affluence. In the past two decades, there has been an increase in the number of reported infestation world-wide. Adults are easily visible to the naked eye. They are often described as looking like an apple seed. The attached article, *How to Identify a Bed Bug Infestation*, provides an overview of identification of bed bugs.

B. Preventative measures

1. Our Health contracts with a local pest management business for monthly pest control. Sticky traps are an effective and inexpensive way to catch the introduction of the pests soon after introduction.
2. Carpeted surfaces should be vacuumed daily and the bag discarded daily.
3. When purchasing new furniture, avoid upholstered pieces and choose leather or vinyl. If upholstered is used, attempt to prevent access by ensuring the furniture stands on metal legs and the fabric is several inches above the floor.
4. Educate all staff on:
 - a. General information on bed bugs
 - b. How to inspect for and detect bed bugs
 - c. How to report the detection of bed bugs
 - d. How to prevent spread of infestation

C. How to inspect for bed bugs

1. Bed bugs can be found anywhere and everywhere. Generally, bed bugs seek out dark and hidden places like cracks, crevices and hole. They prefer textured surfaces like wood, fabric, and paper. They are less often found on smooth surfaces like metal, glass, and plastic.
2. Inspect the following for the presence of bed bugs (including fecal spots and molted skins):
 - a. Mattress, box springs, and bed frame. Look closely between all crevices. Remove any mattress covers, inspect slats, joints, and behind the headboard.
 - b. Wall, especially in cracks, behind baseboards, picture frames, wall hangings, and electrical outlets.

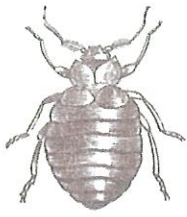
- c. Floors, particularly in joints where floor and wall meet, under rugs, and under edges of wall-to-wall carpet.
 - d. Furniture, removing cushions. Check cracks and crevices in all surfaces. Inspect contents of drawers, especially cloth.
 - e. Lamps, clocks, electronic equipment, bedding, purses, backpacks, and other belongings.
- D. If a family reports the presence of bed bugs in the home, isolate personal belonging in plastic bags, and store separately from other items. Notify a director immediately. Nursing staff or CNAs should examine the participant's skin and clothing during toileting, and report any suspected bites to nursing staff or a director.
- E. If bedbugs (dead, alive, or traces of) are detected at the Center, notify a director **immediately**. Our Health will coordinate extermination.
- F. To prevent spread of the infestation if bed bugs are found at the Center:
1. All staff should leave all personal belongings (purse, backpack, etc.) at home or in their cars. Avoid wearing slacks with long legs, long skirts, or other apparel that could touch the floor.
 2. Staff should keep alcohol wipes in their cars, and wipe off shoes before entering the car. Shake out clothing/coat. Wash clothes in the hottest water possible at home, and dry on the hottest dryer setting.
 3. Shake out participant outerwear before entering the Center, if possible. Place coats in plastic bags for the day. Inspect participants and clothing on arrival and during toileting.
 4. Ask participants to leave purses at home.
 5. If a live bed bug is found on a participant, isolate the participant, call the family and request immediate pickup. Describe what was found (if possible, using gloves, place insect into a tightly sealed double bagged plastic bag).
 6. If a dead bug is found on a participant, the participant may stay at the Center, but contact the family to let them know that they may want a home inspection conducted.

VI Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or staff RN. Notes may be made on the procedure by the Executive Director or staff RN, but must be dated and initialed.

Signature: Oprie Burkhardt

Date: 6-11-2020

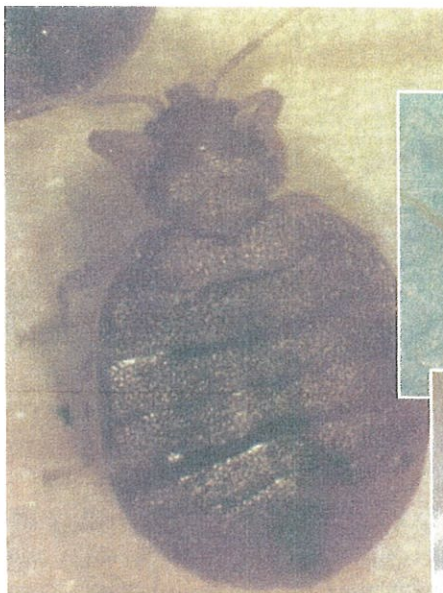


How to Identify a Bed Bug Infestation

Dini M. Miller, Ph.D., Department of Entomology, Virginia Tech

Introduction

You cannot just “get” bed bugs. They have to be brought into your home. So what is your first clue that you have brought bed bugs home in your luggage after a trip, or on a piece of used furniture that you bought at a garage sale? Most people become suspicious of a bed bug infestation when they find unexplained bites on their bodies. Most commonly a person will go to bed feeling fine but wake up in the morning with itching bites. While bites might suggest bed bugs, they are not a good method for diagnosing a bed bug infestation. This is because bite reactions are so variable from person to person. For instance, a person who has been bitten while traveling may not react for several days, and only notice the bites after they have returned home. These bites do not mean the home is infested. Alternatively, a person may not react to bed bug bites at all. This can allow an infestation to get started in their home and remain unnoticed until the bed bug population increases so much that bed bugs start to be seen. Because bites are an unreliable indicator of an infestation (they may not be bed bug bites at all), it is very important to be familiar with the other signs that bed bugs leave behind to detect a real infestation (particularly a small one). By looking for specific bed bug evidence, the infestation can be identified early before the population becomes difficult to control.



Bed Bug Identification



It is very important to know what bed bugs look like. The adults can easily be seen with the naked eye. Adult bed bugs are reddish brown in color, wingless, and are about the size of an apple seed. Immature bed bugs (there are 5 immature or nymphal instar stages) can also be seen with the naked eye but they are smaller than adults, and translucent whitish-yellow in color. The most difficult life stage to see is the first instar nymph. This is the youngest life stage that hatches out of the egg. These nymphs are so small that they are difficult to see unless they are moving or have recently fed (bright red when full of blood). Bed bug eggs are also tiny, about the size of the head of a pin. The eggs are a pearl-white color and have obvious eyespots if they are older than 5 days.



Bed bugs can look somewhat different depending on their feeding status. If an adult bed bug has not fed recently, it is approximately $\frac{3}{16}$ " long and oval in shape. In fact, an unfed bed bug can look like a flat disc. However, once it takes a blood meal the body blows up like a balloon. The bed bug elongates so that it looks more like a torpedo than a disc. The color also will be a bright red if the bed bug has fed within the last couple of hours. The bed bug will darken and flatten again over the next couple of days as it digests the blood meal.

Bed bug nymphs also change in their appearance after a blood meal. A hungry bed bug nymph is almost completely pale white or yellowish. However, once it is fed it plumps up, becomes brilliant red, and looks like a plump raspberry seed. Nymphs are the easiest to see when they have recently eaten.

Identifying Molted Skins

Immature bed bugs have to take a blood meal in order to grow, and molt to the next life stage. The molting process is where the bed bug has to shed its "skin." Because all insects (like the bed bug) have their skeleton on the outside of their body (exoskeleton), they have to shed it in order to grow larger in size. Because each bed bug has five immature stages before it becomes an adult, it will have to molt (shed) five times. After adulthood, the bed bug no longer grows or sheds its skin. In a large infestation there will be many thousands of these molted skins lying around where they bed bugs have left them behind. In a new infestation, say in a hotel room, bed bug evidence may be very hard to find. Yet, because the largest percentage of any bed bug population is always in an immature stage, there is always potential to find these cast skins.

The molted skins of the bed bug look very similar to the bed bug itself. They are the same shape and generally translucent in color. However, you will notice that they look like an empty bed bug shell. They will be different sizes depending on the life stage of the bed bug that molted. In small infestations, molted skins can be found almost anywhere. In large infestations, most are found in areas where bed bugs aggregate together in groups.

Where to look for molted bed bug skins:

- Along mattress seams
- Behind head boards
- In ceiling/wall junctions
- Along baseboards
- Stuck to personal belongings



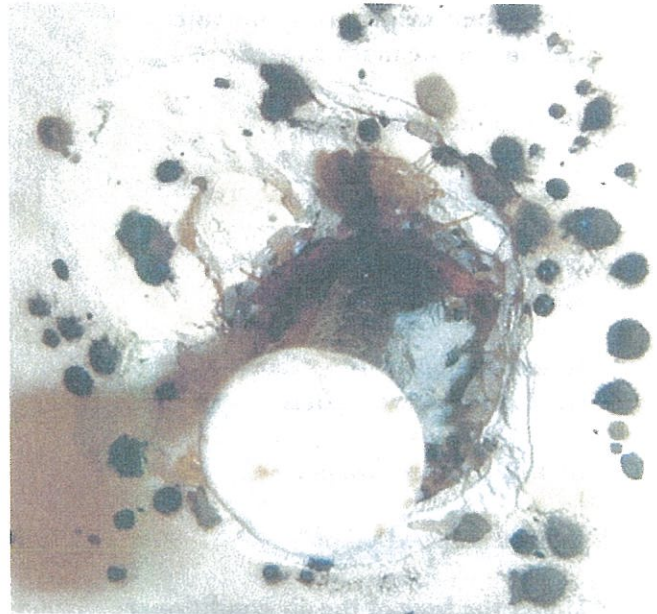
Identifying Fecal Spots

Bed bugs feed every 5-7 days if a host is present. On the days they are not feeding, they spend their time digesting their previous meal. Blood contains a lot of water so the bed bugs must condense their meal right away and excrete some of the excess liquid as waste. This digested blood is then deposited wherever the bed bugs happen to go

after feeding. The excreted waste comes out in a semi-liquid form and can be easily seen on the surfaces of mattresses, bed frames and other locations where the bed bugs travel or aggregate. These fecal spots are black in color (not red because the blood has already been digested) and are often seen in groups of 10 or more. However, if the infestation is low, and the bed bug was just passing through the area, there may be only one or two spots in a particular location. Fecal spots can be found anywhere in a large infestation, but when the infestation is small, there are some places where fecal spots are more likely to be found. See below.

Where to look for Fecal Spots:

- Along the mattress seams and on the tag
- On the wood frame of the box springs
- Behind the head board
- Along the tops of baseboards or the edge of carpeting
- Ceiling/wall junctions and behind pictures on the wall
- At electrical outlets
- In curtain seams where they gather at the rod



Notice that the bed bug fecal spotting can look similar to German cockroach feces that you might find in an apartment with a heavy cockroach infestation. One way to tell these two types of fecal spots apart is to first look for additional bed bug evidence in the area. Do you see shed skins or hatched eggs? If not, touch the fecal spots (yes, touch them). Bed bug fecal spots have a smooth feel because they consist of a dried liquid food (blood). German cockroach feces tend to feel very granular because they contain solid wastes.



Identifying Bed Bug Aggregations

Looking for bed bug aggregations is similar to looking for fecal spots in that bed bugs often leave numerous fecal spots where they aggregate together after feeding. However, these aggregations also contain a variety of other bed bug evidence:

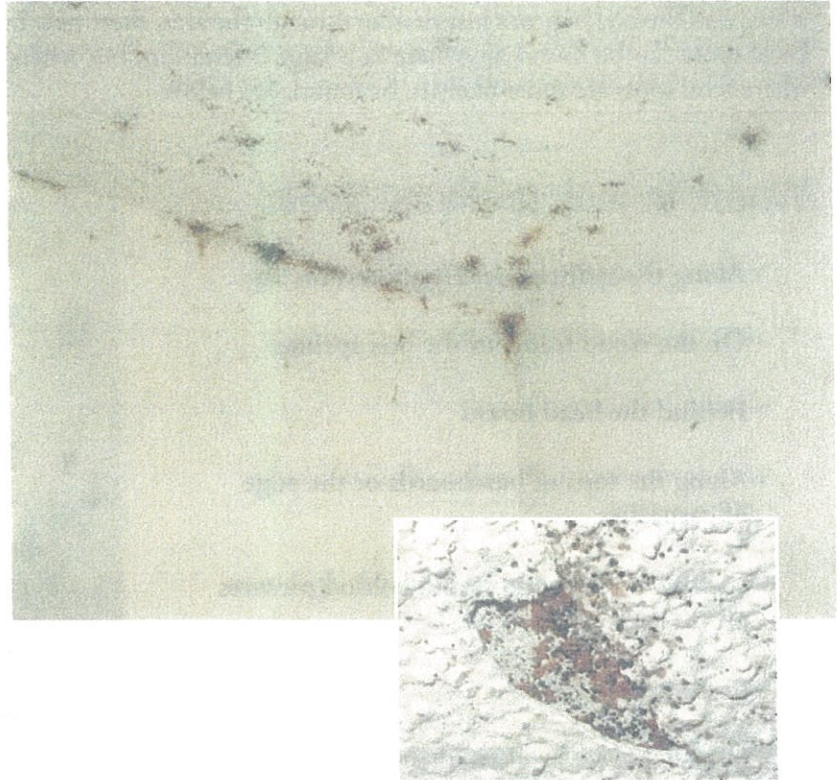
- Live bed bugs (multiple life stages)
- Fecal spots
- Cast skins (from nymphs that have molted)
- Live and hatched eggs

Although the photograph above makes a bed bug aggregation look obvious, these aggregations are not so easily identified if you do not look closely. For example, take a look at the photograph taken of an apartment ceiling on the next page. At first glance, this looks like mold or mildew

problem, indicative of a moisture issue coming from the apartment upstairs. However, if you look more closely you can see that the “mold” is actually numerous aggregations of bed bugs on the ceiling. The black material is the fecal spotting described previously.

Where to look for bed bug aggregations:

- Along mattress seams, in the tufts and under the mattress tags
- Behind the headboard
- Inside the holes for set-in screws
- Along wood creases in the box springs or in bed frames
- Where the box springs fabric is stapled to the wood frame
- Behind loose wallpaper
- Behind chipped paint
- Under the base of the air conditioner
- Beneath the wood framing that holds the bar in the closet
- Along the interior frame of closet doors
- Behind baseboards
- Inside the baseboard heaters
- Inside curtain rods, and on the curtains near the top where they are pleated
- In personal belongings, including books, stuffed animals, picture frames and hundreds of other locations



Summary

The first clue suggesting that you may have a bed bug infestation is often the presence of itching bites. However, bites reactions are quite variable and may not be due to bed bugs at all. Be aware of the other signs that bed bugs leave behind: fecal spots, molted skins, and aggregations.



Bed Bug Inspection Log

Date	Results

C

C

C

Procedure to Apply and Remove Personal Protective Equipment (PPE)

I Purpose and background

The type of PPE used will vary on the level of precaution needed.

II Definitions

All terms are defined in the text.

III References

<https://cdc.gov.hk/pdfs/ppe/ppe-sequence>

IV Procedure

A. To apply PPE:

1. Put on the gown so that it is open in the back. Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. Fasten in back of neck and waist.
2. Secure contact/droplet mask ties or elastic bands at the middle of the head and neck. Secure N-95 respirator mask per procedure directions.
3. Apply goggles or face shield if desired.
4. Apply gloves, extending the glove to cover the wrist of the gown.

B. To remove PPE (before leaving the room):

1. Remove gloves first (assume the outside of the glove is contaminated):
 - a. Use a gloved hand to grasp the palm of the other hand and peel off the first glove, then hold the removed glove in the gloved hand.
 - b. Slide the fingers of the ungloved hand under the remaining glove at the wrist, and peel off the second glove over the first glove.
 - c. Discard.
2. Remove goggles/face shield (if used) and set aside. Perform hand hygiene, as the outside surface is assumed to be contaminated.

3. The gown front and sleeves are considered to be contaminated.
 - a. Unfasten ties, taking care that sleeves don't contact your body when reaching for the ties.
 - b. Pull gown away from the neck and shoulders, touching only the inside of the gown.
 - c. Turn gown inside out, and roll into a bundle. Discard.
4. Remove mask (assume the front is contaminated):
 - a. Contact/droplet mask: Grasp bottom ties or elastics and then the ones at the top, and remove without touching the front. If your hands touch the front of the mask, immediately perform hand hygiene. Discard.
 - b. N-95 mask: follow the directions in the N-95 procedure.
5. Perform hand hygiene.
6. Cleanse goggle surface with EPA-approved disinfecting wipe (if available, substitute generic if necessary) or Clorox disinfecting solution (4 t. Clorox bleach to 1 quart of water). If Clorox is not available, a generic can be substituted if necessary. Rinse and allow to dry. Avoid cleansing the elastic band, if present. Goggles with an elastic band cannot be shared but must be dedicated to one staff member after first use. Goggles with rigid ear pieces may be shared after decontaminating the entire surface.

Cleanse face shield with the Clorox disinfecting solution described above, rinse with water and allow to dry. Face shields cannot be shared but must be dedicated to one staff member after first use.

- C. Due the presence of COVID-19 in the community, a mask may be reused until it is visibly damaged or becomes wet. Masks will not be shared with another individual.

V. Document control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or the staff RN. Notes may be made on the procedure by the Executive Director or staff RN, but must be dated and initialed.

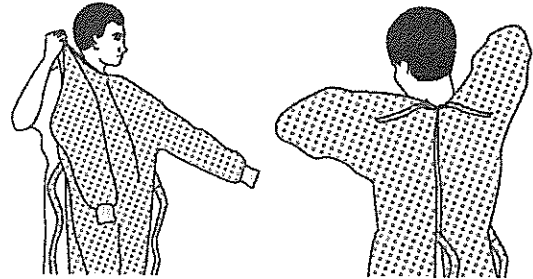
Signature: Jane Blankner Date: 6-11-2020

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

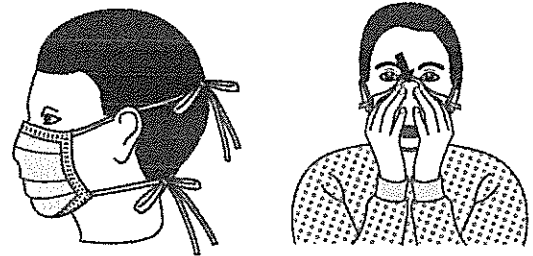
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



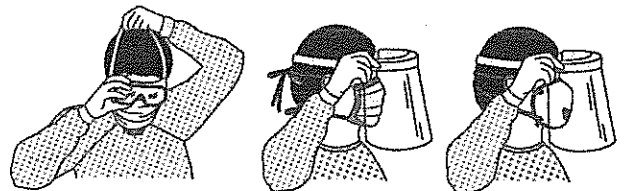
2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



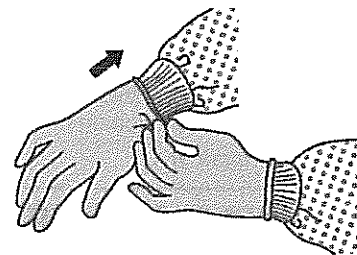
3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

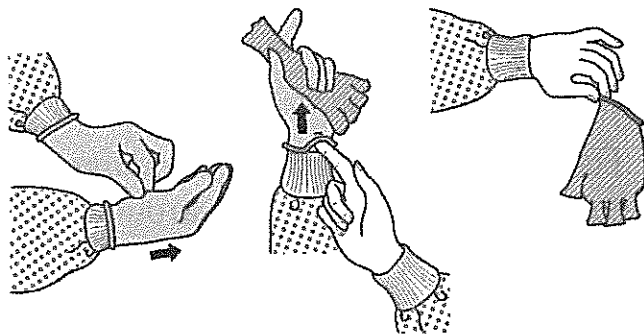


HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



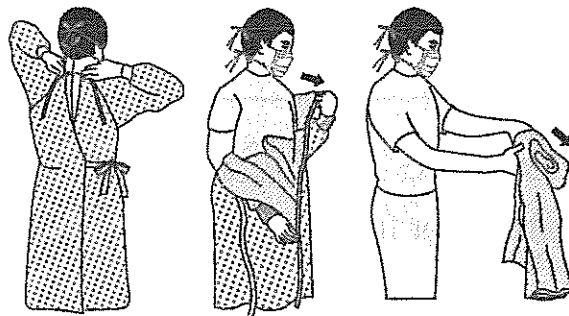
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



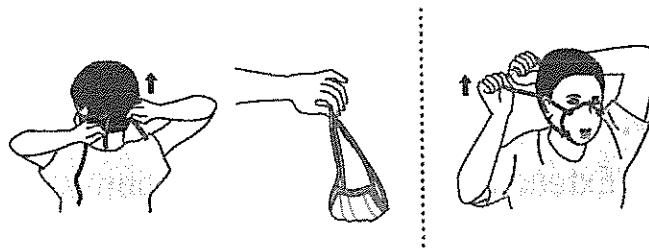
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

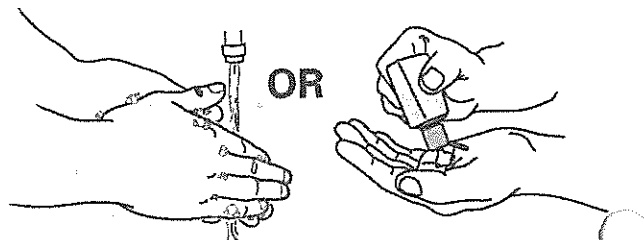


4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — **DO NOT TOUCH!**
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS
BECOME CONTAMINATED AND IMMEDIATELY AFTER
REMOVING ALL PPE**

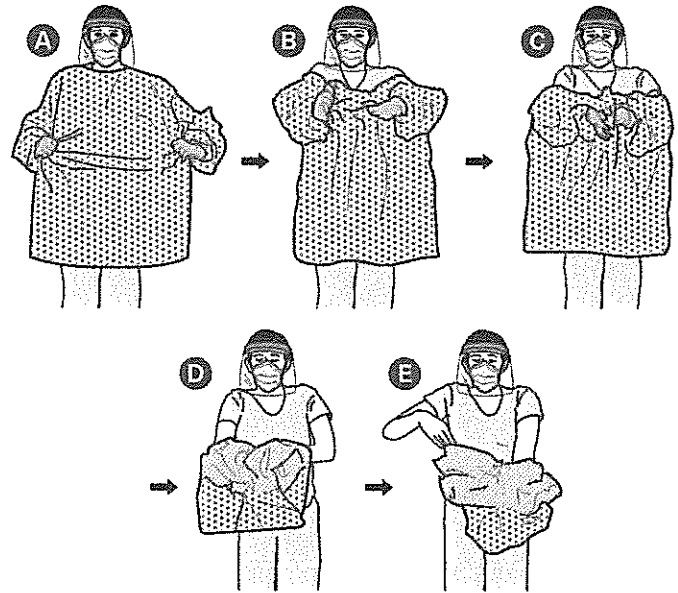


HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



GOGGLES OR FACE SHIELD

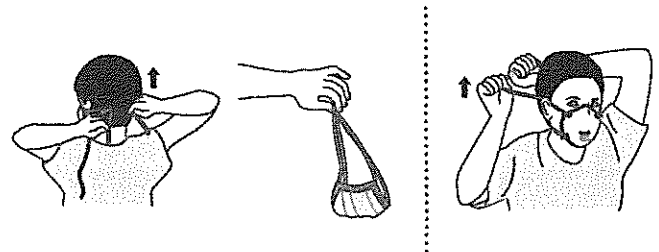
Outside of goggles or face shield are contaminated!

- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

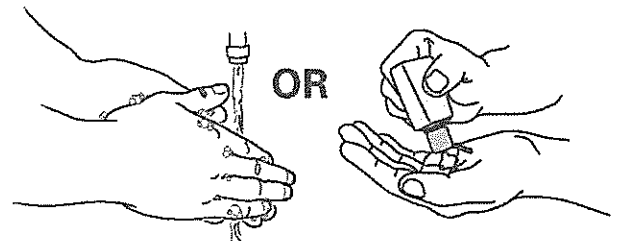


3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS
BECOME CONTAMINATED AND IMMEDIATELY AFTER
REMOVING ALL PPE**





Procedure for Administration of Insulin from an Insulin Pen

I Background

Insulin (native or administered) is required for life. The medication must be accurately measured and delivered. Incorrect administration may be a life-threatening event. The nurse or medication aide should be familiar with acceptable administration sites, the type of insulin to be administered, the participant's current blood glucose level, the timing of the next meal, and symptoms of elevated and low blood glucose. Review the medication administration record (MAR) and insulin source before preparing all materials.

This procedure is not a comprehensive review of medication administration, and insulin pen instructions vary by manufacture. This procedure is based on the use of the Novolog FlexPen, as it is the most commonly prescribed pen at the Center.

Insulin is only to administered by a registered nurse or a medication aide.

II Definitions

All terms are defined in the text.

III References

- A. Perry A. and Potter P. (2006). *Clinical Nursing Skills & Techniques* (6th ed.). (pp. 716-723). St. Louis, MO: Elsevier Mosby.
- B. Novolog FlexPen at
https://www.novomedlink.com/content/dam/novonordisk/novomedlink/resouces/generaldocuments/Norolog%FlexPen%20Ifu%20PDF_LOCKED.pdf

IV Procedure

A. Preparation

1. Inspect pen to ensure that adequate insulin is available.
2. Remove needle if present and discard into a sharps box. Cleanse the base of the pen with a sterile alcohol wipe and allow to dry. Attach a new needle.
3. Dial up 2 units of insulin, remove both caps and raise the tip vertically. Dispense insulin and discard to prime the system. At least one drop of insulin should dispense from the needle.

4. Assemble all items needed.

B. Finger stick and insulin administration

1. Perform finger stick per physician's order.
2. Consult medical administration record (MAR) to determine dose to administer.
3. Cleanse injection site with sterile alcohol pad, allow to dry.
4. Dial in correct number of units for administration.
5. Remove tip, hold pen at a 90-degree angle to the skin.
6. Insert needle, depress plunger, and wait 6 seconds before withdrawing the needle.
7. Observe site for bleeding, treat as needed.

C. If another type of pen is brought in by the family, follow the manufacturer's instructions for use.

V. Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or the staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Signature: Jane Bauknecht Date: 6-11-2020

Procedure for Disinfecting Blood Pressure Cuffs and Stethoscopes

I Purpose and Background Information

The Centers for Disease Control (CDC) recommend disinfecting blood pressure cuffs and stethoscope heads after each use to prevent disease transmission. The Environmental Protection Agency (EPA) accepts Clorox Disinfecting Wipes as a method of low-level decontamination. Other brands are not accepted.

Decontaminating blood pressure cuffs and stethoscope heads is not considered necessary in the home environment but is recommended for hospital and outpatient care locations.

II Definitions

All terms are defined in the text.

III References

- A. CDC: <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/healthcare-equipment.html>
- B. EPA: <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>
- C. Clorox: <https://www.clorox.com/products>

IV Procedure

- A. After each use, spread out the blood pressure cuff and wipe the inside with one Clorox Disinfecting wipe (if Clorox brand is unavailable, a generic brand may be substituted). Allow four minutes to dry. No rinsing is necessary.
- B. After each use, wipe the head of the stethoscope (where the instrument touched the participant's skin) with the same wipe. Allow four minutes to dry. No rinsing is necessary.

V Document Control

The procedure may be approved by the Executive Director or the Staff Registered Nurse (RN). Revisions may be made by the Executive Director or the staff RN. Notes may be made on the procedure by the Executive Director or Staff RN, but must be dated and initialed.

Signature: Jane Baucknecht Date: 6-11-2020

**Policy for Prompt Reporting of Signs/Symptoms of Potentially Transmissible Illness
to a Supervisor**

Any employee who notices signs or symptoms of a potentially transmissible illness (i.e., coughing, coughing up blood, flushed appearance, unusually warm skin, recurrent sneezing, nasal drainage, diarrhea, vomiting, or rash) will report the findings to the Director, Assistant Director, or Staff Registered Nurse. If none of the above are present, report to a Certified Nurse Assistant.

Approved: Jane Planknecht Date: 6-11-2020

Employee Infection Control Training Checklist
Upon Hiring and Annually

	Date Completed	Trainer Initials
Review Exposure Control Plan (OSHA standards)	_____	_____
Needlestick	_____	_____
*Hepatitis B	_____	_____
*Review CDC standards		
Policy disposable gloves	_____	_____
Policy respiratory hygiene	_____	_____
Policy for shingles	_____	_____
Hand Hygiene	_____	_____
Demonstrate competency	_____	_____
Measles etc. procedure and fitting	_____	_____
N-95 mask	_____	_____
Influenza etc. procedure	_____	_____
Norovirus etc. procedure	_____	_____
C. diff procedure	_____	_____
Procedure to apply/remove PPE	_____	_____
Influenza etc. procedure	_____	_____
Pertussis etc. procedure	_____	_____
Chicken pox procedure	_____	_____
Procedure cleaning BP cuffs	_____	_____
*Review procedure for disinfecting/ sanitizing surfaces	_____	_____
Demonstrate competency	_____	_____
*Review procedure for insulin Administration	_____	_____
Demonstrate competency	_____	_____
Policy for prompt reporting of suspected Illness	_____	_____

*These policies and procedures have to be reviewed annually.

I have been trained in the above policies and procedures.

Employee name: _____ Signature: _____ Date: _____

Trainer name: _____ Signature _____